CERTIFIED NURSE AIDE (CNA) REGISTRY RENEWAL APPLICATION

To renew registration, the CNA shall submit verification of:

a minimum of 12 hours of training **per year** as required in § 44:74:02:02(4), and
a minimum of 12 hours of employment as a CNA for monetary compensation during the preceding 24 months.
Contact diana.weiland@state.sd.us for questions on in-service training requirements.

An incomplete form will result in denial of registration renewal.

THIS SECTION TO BE COMPLETED BY CNA

NAME (FIRST/MIDDLE/LAST):

OTHER NAMES USED (MAIDEN, FORMER):

CERTIFICATE #A0

SS#	DATE OF BIRTH:

ADDRESS:

CITY, ST, ZIP:

HOME PHONE:	EMAIL:
CELL PHONE:	□Native American □Asian/Pacific Islander □Black □Hispanic □White □Other

□YES □NO   I have been employed for monetary compensation as a CNA at least 12 hours within the last 24 months.

□YES □NO   I have completed a minimum of 12 hours of training **per year** (24 hours total) within the last 24 months.

□YES □NO   I have no record of abuse, neglect, or misappropriation, nor is there any pending action.

I declare and affirm that, to the best of my knowledge and belief,
all of the information provided on this application is complete, true, and correct.

CNA SIGNATURE: _____   DATE: _____

VERIFICATION – THIS SECTION TO BE COMPLETED BY EMPLOYER

DATES OF EMPLOYMENT: FROM_____ TO_____ (If presently employed, use "present")

Total number of hours worked during this period: _____

□   This CNA has completed a minimum of 12 hours of training per year within the last 24 months (24 hours total).

□   This CNA has no record of abuse, neglect, or misappropriation, nor is there any pending action.

□   I affirm that, to the best of my knowledge, all information provided on this Verification is complete, true, and correct.

An incomplete form will result in denial of registration renewal.

EMPLOYER: _____

ADDRESS: _____

CITY, ST, ZIP: _____

TELEPHONE: _____   DATE: _____

EMPLOYER REPRESENTATIVE SIGNATURE / TITLE: _____